Utilization Review and Control (BabyCare)

Last Updated: 06/03/2022

Table of Contents

Utilization Review and Control (BabyCare)

Updated: 12/16/2015

Under the provisions of federal regulations, Medical Assistance Programs must provide for continuing review and evaluation of care and services paid by Medicaid and the Children's Health Insurance Program (also knows as Virginia's Family Access to Medical Insurance Security Plan - FAMIS), including review of utilization of the services by providers and by recipients. Federal regulations of 42CFR§§455–456 and 42CFR§§457.490 set forth requirements for detection and investigation of fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on documentation requirements, quality management and utilization review/control requirements handled by the Department of Medical Assistance Services (DMAS).

The Provider Agreement requires that the records fully disclose the extent of services provided to individuals receiving covered services. Records must be made available to authorized state and federal personnel in the form and manner requested.

Providers must follow both the general documentation requirements for all providers and the specific documentation requirements for BabyCare services as outlined in this chapter. Documentation must be in accordance with the requirements of the individual licensing board within the Department of Health Professions and the requirements detailed in this manual.

General Documentation Requirements

Use of the electronic signatures, for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers must follow DMAS guidelines set forth regarding electronic signatures (DMAS Memorandum "Use of Electronic Signatures" 8/20/2004 available online at: http://dmasva.dmas.virginia.gov/Content_pgs/pr-memos.aspx.

Only a medical doctor (MD) may use a rubber stamp and the stamped signature must be initialed and dated by the MD. However, these methods do not override other requirements that are not for DMAS purposes. If a MD chooses to use a rubber stamp on documentation requiring his or her signature, the MD whose signature the stamp represents must have

documented a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The MD must initial and completely date all rubber-stamped signatures.

The provider must recognize the confidentiality of medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern records' use and removal and the conditions for the release of information. The member/responsible party's written consent is required for the release of information not authorized by law.

Record Retention

Regulations of the Virginia Board of Medicine (18VAC85-20-26) state that practitioners must maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

- Records of a minor member, including immunizations, must be maintained until the member reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the member;
- Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or
- Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

After October 19, 2005, practitioners must post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records can only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

NOTE: All forms mentioned in this chapter may be located at the DMAS website at: http://dmasva.dmas.virginia.gov/.

Financial Review and Verification

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

BabyCare Requirements

Eligibility

Recipients must be eligible for Fee-for-Service (FFS) or Primary Care Case Management, Medicaid, FAMIS, FAMIS Plus or FAMIS MOMS on the date of service. Maternal members must be either pregnant or up to the end of the month following their sixtieth day post-partum. Infant members are eligible for BabyCare case management up to their second birthday.

Member's Consent for BabyCare Services

Individuals cannot be forced to receive BabyCare services for which they might be eligible. The member/member's primary caregiver must agree to be open for services and refusal of services will not negatively impact the member's benefits.

Note: DMAS requires the completion of the Letter of Agreement (DMAS-55) or equivalent to support the member's or member's primary caregiver willingness to be open for BabyCare services. The documentation should be kept in the member's medical record.

Member Choice and Involvement in the Planning Process

- Documentation must indicate that the member was given a choice of available BabyCare Service providers.
- Documentation must indicate that the member or member's caregiver was involved in the assessment, Service Plan development and any changes to the Service Plan.

Screening Requirements

DMAS will reimburse providers, as defined in Chapter II of this manual, for administering the *Behavioral Health Risks Screening Tool* {DMAS 16-P (Provider) and DMAS 16-S (Self-Instrument)} . The completed screening tool and outcome including referrals must be documented in the member's medical record. This tool replaces the BabyCare Maternity Risk Screen (DMAS 16) and the BabyCare Infant Risk Screen (DMAS 17).

Note: Practitioner's may document in the infant's medical record for completion of a screening of the infant's mother, that a "risk assessment" has been performed. To maintain

the confidentiality of the mother's screen, keep the screening tool and results in a separate file.

Universal Referral Form

DMAS has approved the use of the *Virginia Home Visiting Consortium's Universal Referral Form* as a template for use as a referral mechanism to BabyCare. BabyCare providers may adapt the form and change it to meet their community's needs. Note: Referrals to BabyCare are not a reimbursable service. DMAS has removed the requirement for a "Risk Screen" to be completed to initiate a referral to BabyCare. This change was made to reduce any potential barriers for an at-risk pregnant or infant enrollee to be referred for BabyCare services.

Case Management Documentation Requirements

BabyCare providers must maintain records for each member which includes, at a minimum, the following information:

- Evidence that the member or member's primary caregiver has agreed to be open to services (via Letter of Agreement DMAS 55 or equivalent)
- Identification of the member on each entry by full name and Medicaid/FAMIS ID number;
- Documentation must be clear and legible;
- Signatures and complete dates are required for all documentation or entries and must include, at a minimum, the first initial and last name and credentials;
- Written documentation verifying the qualifications of the nurse or social worker providing the services must be maintained and available for review;
- All contacts and attempted contacts (face-to-face, telephonic and collateral) signed and dated by the individual providing the service;
- Evidence of coordinating care with the member's primary care provider (PCP);
- A timeline for obtaining needed services as well as a timeline for reevaluation of the Service Plan (via DMAS 52 or equivalent);
- All interventions to include the nature and content of services received and which goals the intervention is addressing;
- Documentation of the need for, and occurrences of, coordination with other case managers;
- Copies of all required forms, or equivalents, as specified within this chapter;
- If the nurse or social worker was not able to complete the initial face-to-face assessment (via DMAS 50 (M)aternal or (I)nfant) within the first 30 calendar days

from date of referall, there must be specific documentation to the reason the face-to-face contact did not occur;

- Documentation must be evident that the member is receiving services as detained in the Service Plan during any month in which billing for services occurs; and
- The Service Plan must address needs identified in the case manager's assessment and be reviewed and updated as necessary to reflect changes in the member's service needs.

Services may not duplicate any other covered service provided under the Medicaid or FAMIS State Plans or other Medical Assistance programs. If the BabyCare case manager is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate the case management services from other service provisions.

High Risk Case Management Service authorization Request Form (DMAS 50 M/I)

During the initial face-to-face meeting, the nurse or social worker completes a comprehensive assessment and documents this on the BabyCare Service authorization Request form (DMAS 50 [M]aternal or [I]nfant) and notes this as entry in member's medical record.

The following documentation is required to be completed on the assessment for service authorization of case management services:

- Member's name;
- Medicaid/FAMIS ID number;
- Member's date of birth;
- Pregnant member's obstetric history (Gravida, para, AB elective, AB Spontaneous);
- Pregnant member's estimated date of delivery;
- Date that case management services began;
- Provider's National Provider Identifier (NPI);
- Provider's Agency Name;
- At lease one risk must be checked to indicate at risk pregnancy or infant;
- Signature and date of case manager completing the assessment.

Service Plan

The nurse or social worker uses the information obtained from the assessment to create a Service Plan with the member or member's caregiver. The Service Plan is an

individualized description of what services and resources are needed to meet the service needs of the member and a plan to access those resources. The Service Plan includes active participation of the member or member's caregiver in developing and working towards specified goals. The provider may use the DMAS 52 or equivalent documentation that include the following:

1. The member's identifying information;
2. A list of identified needs/problems identified during the assessment process including medical, social, and educational needs. Resolved problems and/or issues the member does not wish to address may be documented in the member's record;
3. A plan for interventions addressing the identified problems. This includes all necessary referrals; and
4. A plan for follow-up.

After the member is enrolled in case management services, the nurse or social worker conducts periodic reassessments as needed and must update the service plan as necessary.

Closing to Case Management Services

The provider must send a letter stating that the member's case is being closed to the member and the member's primary care provider or referring provider.

DMAS no longer requires the provider to submit notification of the closure of member's case. Upon closure of case to BabyCare case management, DMAS requires that the provider document the following in the member's medical record, including the following:

- Documentation of Part C referral if infant appears to not be developing as expected or who have a medical condition that can delay normal development.
- Documentation of the *Behavioral Health Risks Screening for Women of Childbearing Age* administration and outcome, as applicable.
- The referrals that were initiated upon closure to case management for purposes of discharge planning.
- Signature of case manager and date completed.

Expanded Parental Services

Member Education Classes

A written record must be kept for each member which includes:

- The member's name and Medicaid/FAMIS ID number;
- The course being provided;
- The instructor teaching the course; and
- Verification through the member's signature of the dates of each course session attended.

Nutrition Services

The provider of nutrition services must develop a written dietary assessment for each member which includes, at a minimum, the following information: height and weight measurements (including pregravid weight), laboratory values, dietary habits, socioeconomic status, complications of pregnancy involving a nutrition component, a nutrition care plan for follow-up and referral based on individual needs, and provide nutrition counseling based on the assessment and care plan. Documentation of participation in food assistance programs such as WIC or the Supplemental Nutrition Assistance Program (SNAP) should also be included. It is also acceptable to maintain laboratory values in the laboratory section of the member's record.

Documentation for the nutrition follow-up visits must include progress notes which document how the concerns found in the initial assessment have been addressed.

Blood Glucose Monitors

The physician must follow the guidelines for ordering blook glucose monitors which is detailed in the DMAS Durable Medical Equipment (DME) Provider manual available online at www.dmas.virginia.gov. When a physician determines that a pregnant enrollee is at risk due to her diabetes and authorizes the use of a blood glucose monitor, Virginia Administrative Code requires that the a referral to a nutritionist be completed. The ordering physician must indicate in the member's medical record that a referral for nutrition counseling was initiated.

Homemaker Services

A written record must be kept which includes the following:

- A referral from the primary care provider supervising the member's prenatal and/or postpartum care which states that the member is confined to bed for a specific period of time;
- An assessment performed by the supervisor of the homemaker service that states what services are required for the normal functioning of the bed-bound member's household. The assessment should reflect inquiries into such elements as: the number and age of persons in the household, availability of assistance by relatives/friends, needs as perceived by the bed-bound member, etc.;
- A Service Plan developed based on the needs assessment that states specific services needed and the frequency of services;
- All documentation for the extension of services, if necessary;
- Services rendered and length of the visit by the homemaker; and
- Signatures by the homemaker and the member verifying services received for each date of service.

Homemaker services rendered must be reviewed monthly by the supervisor and documented in the record. Flow sheets may be utilized by the homemaker and/or the supervisor for documentation purposes.

DMAS Quality Management Review Responsibilities

Quality management controls are important to ensure quality of care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to Federal and State regulations; all participating providers must comply with all of the requirements.

DMAS or its contractors must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to members.

Medical records of members currently receiving DMAS reimbursable services as well as a sample of closed medical records may be reviewed. DMAS or its contractors may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, quality management review on-site visits or desk reviews will be made. Review may include but is not limited to:

- The comprehensive care being provided;
- The adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each member for the scope of services offered;
- The necessity and desirability of the continued services;
- The documentation to support medical necessity and authorization for services; and

- For verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, DMAS staff will meet with staff members for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings. Based on the review team's report and recommendations, DMAS may take corrective action. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services.

If DMAS requests corrective action plans, the provider must submit the plan, within 30 days of the receipt of notice. Subsequent visits/desk reviews may be made for the purpose of follow-up deficiencies, complaint investigations, or to provide technical assistance.

Reimbursement Requirements

Services that fail to meet DMAS criteria are not reimbursable. Such non-reimbursable services may have payment retracted as a result of a quality management review. DMAS criteria for general reimbursement of general Medicaid/FAMIS services provided are found throughout the provider manual. It is the responsibility of the provider to adhere to the requirements documented in this manual as well as by the individuals licensing board.

Referring Members to Client Medical Management

DMAS providers may refer Medicaid/FAMIS patients suspected of inappropriate use or abuse of Medicaid/FAMIS services to the Recipient Monitoring Unit (RMU) in DMAS. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program (CMM). If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

FAX: (804) 786-5799

When making a referral, provide the name and Medicaid/FAMIS number of the member and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the “Non-Emergency Use of the Emergency Room” Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Fraudulent Claims

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from

that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219